Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of requestor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_

Contact phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, authorize the release of, or request access to the information specified below for the medical record(s) of the above named patient.

The following information is authorized to be disclosed (please check all that apply):

\_\_\_\_\_\_ Complete Medical Record \_\_\_\_\_\_ History & Physical Forms \_\_\_\_\_\_Progress Notes

\_\_\_\_\_\_ Laboratory Results \_\_\_\_\_\_ Radiology Reports & Images \_\_\_\_\_Hospital Records

\_\_\_\_\_\_ Emergency Room Records \_\_\_\_\_\_ Medication Records \_\_\_\_\_ Other

Reason for request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO:**

Alamo Heights Pediatrics

1919 Oakwell Farms Parkway, Suite 257

San Antonio, TX 78218

Phone: 210-930-8400 Fax: 210-930-8402

FROM (previous provider):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Practice, Doctor, Hospital) (Phone number/Fax number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address City, State and Zip

I understand that my records are confidential and cannot be disclosed without my written authorization , except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I do understand that the office transferring the medical records has 15 days to comply with this request and that this consent shall automatically expire 180 days from the date set forth below. The patient can revoke this authorization in writing any time prior to the expiration date. I also understand that a fee for preparing and furnishing this information ma be charged according to the rules set forth b the Texas State Board of Medical Examiners.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent, Patient or Legally Authorized Guardian Date